Ladies First

Keeping Vermont Women Healthy

VERMONT DEPARTMENT OF HEALTH

Thank you for your interest in Ladies First. We look forward to having you as a member.

Please fill out the enclosed application, read the privacy notice, and return the signed application. If you have questions, call 1-800-508-2222; or, for deaf and hard of hearing individuals, please use Vermont Relay Service 711 and give our number: 1-800-508-2222.

Checklist to complete your Ladies First application:

- ☐ read and fill out the Ladies First Application;
- ☐ read the Notice of Privacy Practices;
- ☐ sign the application at the bottom of page 5;
- ☐ mail us your signed application;
- ☐ keep the Notice of Privacy Practices for your records.

Mail your application in the enclosed postage paid envelope to:

Vermont Department of Health
PO Box 70 Drawer 38 (LF)
Burlington, VT 05402-0070

Ladies First Application

Ladies First is a breast and cervical cancer and heart health screening program for women who meet specific guidelines. Women who have Medicaid or Medicare Part B are not eligible for Ladies First.

Ladies First
Keeping Vermont Women Healthy

Mail this application to:
Vermont Department of Health, PO Box 70 Drawer 38 (LF), Burlington, VT 05402-0070

For deaf and hard of hearing individuals, please use Vermont Relay Service 711 and give our number: 1-800-508-2222.

If you have questions or need interpretation services, call 1-800-508-2222.

Si vous avez des questions ou besoin de services d'interprétation, composez le 1-800-508-2222.

Ukoliko imate dodatnih pitanja ili Vam je potreban prevodilac, javite se na 1-800-508-2222.

Si usted tiene preguntas o necesita servicios de interpretación, llame al 1-800-508-2222.

Haddii aad su'aalo qabto ama aad u baahan tahay adeeg tarjumaan, wac lambarka hoos ku qoran 1-800-508-2222.

Kama una maswali au unahitaji huduma za tafsiri, piga 1-800-508-2222.

စကားပြန် ဝန်ဆောင်မှုလုပ်ငန်းကိုအလိုရှိပါက 1-800-508-2222 သို့ဖုန်းဆက်ခေါ်ပါ။

यदि तपाईंलाई दोभाषे सेवाको जरुरत परेमा, 1-800-508-2222 मा कल गर्नुहोस्।

Section 1: Tell us about yourself.

Are you already a member of Ladies First? ☐ Yes ☐ No

Name *(your legal name or as it appears on Social Security card)*:

Date of birth: _____ /_____ /_____

Social Security number:

Street address *(required)*:

E-mail address:

City State Zip Code

Primary phone number: ☐ Home ☐ Work ☐ Cell

( ) _____ - _____

Is it ok to leave a message? ☐ Yes ☐ No

What is the best time to reach you? ☐ Anytime ☐ 9:00–11:00 ☐ 11:00–1:00 ☐ 1:00–3:00 ☐ 3:00–5:00 ☐ After 5:00

Mailing address *(if different than above)*:

City State Zip Code

Alternate phone number: ☐ Home ☐ Work ☐ Cell

( ) _____ - _____

Is it ok to leave a message? ☐ Yes ☐ No

What is the best time to reach you? ☐ Anytime ☐ 9:00–11:00 ☐ 11:00–1:00 ☐ 1:00–3:00 ☐ 3:00–5:00 ☐ After 5:00

Do you live in Vermont? ☐ Yes ☐ No

Are you a U.S. Citizen or Qualified Alien? ☐ Yes ☐ No

Are you of Latino or Hispanic origin? ☐ Yes ☐ No

What race or races do you identify with? (Select up to 2)

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska native
- ☐ Don't know/Not sure
- ☐ Don't want to answer

What is the highest grade you have completed?

- ☐ Less than 9th grade
- ☐ Some high school
- ☐ High school graduate or equivalent
- ☐ Some college or higher
- ☐ Don't know/Not sure
- ☐ Don't want to answer

What is the primary language spoken in your home?

☐ English ☐ Spanish ☐ Arabic ☐ Chinese ☐ French ☐ Vietnamese ☐ Other _____ ☐ Don't want to answer

Section 2: Tell us about your INCOME. Must be filled out even if you have given us this information in the past.

Your application will be returned if you do not complete this section. If you have questions about how to answer please call 1-800-508-2222.

Total household income before taxes: $_____ per year OR $_____ per month OR $_____ per week.

Total number of people who live on this income: _____ Include yourself, spouse/civil union partner, and children who are claimed on tax return.

Section 3: Tell us whether or not you have health insurance.

☐ I do not have health insurance at this time. **Please go to Section 4**.

☐ I have health insurance. **Please tell us about your insurance below.** Please note, if you have Medicaid or Medicare Part B you are not eligible for Ladies First.

Name of insurance company:	Where do you get your insurance? Check one answer below.
	☐ Through work: _____
Insurance company's address:	☐ An individual Blue Cross Blue Shield plan through Vermont Health Connect
	☐ An individual MVP plan through Vermont Health Connect
	Other: _____

Coverage start/end date *(required)*: _____ until_____ *(leave blank if no end date)*

Policy holder's name:	Policy holder's Social Security number:
Policy or ID number:	Group or account number:

Section 4: Tell us about your health history.

Do you have a doctor, physician assistant, or nurse practitioner? ☐ Yes ☐ No If yes, give us the name of provider and practice name.

Provider/Practice name: _____

Provider/Practice phone number: ( ) _____ - _____ If no, do you need help finding one? ☐ Yes ☐ No

Is this your first Pap test? ☐ Yes ☐ No If no, list the approximate dates/locations of your last **two** Pap tests.

Date: ___ /___ /___ Provider/Practice name: _____

Date: ___ /___ /___ Provider/Practice name: _____

Have you had an abnormal Pap test? ☐ Yes ☐ No

Is this your first mammogram? ☐ Yes ☐ No If no, list the approximate dates/locations of your last **two** mammograms.

Date: ___ /___ /___ Provider/Practice name: _____

Date: ___ /___ /___ Provider/Practice name: _____

Do you have any breast changes or concerns? ☐ Yes ☐ No

Have you had your cholesterol checked? ☐ Yes ☐ No If yes, when/where?

Date: ___ /___ /___ Provider/Practice name: _____

Do you smoke cigarettes? ☐ Every day ☐ Some days ☐ Not at all ☐ Don't know ☐ Don't want to answer

If yes, could we make a referral to 802Quits for you? ☐ Yes ☐ No

Does 802Quits have permission to leave a detailed message on your answering machine voice mail or with the person who answers the phone? ☐ Yes ☐ No

You have a better chance of successfully quitting tobacco when you use one of our resources online, by phone or in-person. To find out more about these programs and how you can get free Nicotine Replacement Therapy, visit us online at www.802Quits.org or call 1-800-QUIT-NOW (784-8669). Please identify yourself as a Ladies First member.

Section 4, continued: Tell us about your health history.

Our program is required to collect these questions on an annual basis. Your responses will help us better serve you and connect you to resources and lifestyle programs that support your health.

1. Do you have high cholesterol?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know/Not sure
   - ☐ Don't want to answer

2. Do you have hypertension (high blood pressure)?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know/Not sure
   - ☐ Don't want to answer

3. Do you have diabetes (either Type 1 or Type 2)?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know/Not sure
   - ☐ Don't want to answer

4. Have you been diagnosed by a healthcare provider as having any of these conditions: coronary heart disease/chest pain, heart attack, heart failure, stroke/transient ischemic attack (TIA,) vascular disease or congenital heart defects?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know/Not sure
   - ☐ Don't want to answer

5. Do you take medication to lower your cholesterol?
   - ☐ Yes
   - ☐ No
   - ☐ No – could not obtain medication
   - ☐ Not applicable
   - ☐ Don't know/Not sure
   - ☐ Don't want to answer

6. Do you take medication to lower your blood pressure?
   - ☐ Yes
   - ☐ No
   - ☐ No – could not obtain medication
   - ☐ Not applicable
   - ☐ Don't know/Not sure
   - ☐ Don't want to answer

7. Do you take medication to lower your blood sugar (for diabetes)?
   - ☐ Yes
   - ☐ No
   - ☐ No – could not obtain medication
   - ☐ Not applicable
   - ☐ Don't know/Not sure
   - ☐ Don't want to answer

8. During the past 7 days (including today), on how many days did you take prescribed medication to lower your cholesterol?
   - ___ days
   - ☐ None
   - ☐ Not applicable
   - ☐ Don't know/Not sure
   - ☐ Don't want to answer

9. During the past 7 days, on how many days did you take prescribed medication (including diuretics/water pills) to lower your blood pressure?
   - ___ days
   - ☐ None
   - ☐ Not applicable
   - ☐ Don't know/Not sure
   - ☐ Don't want to answer

10. During the past 7 days, on how many days did you take prescribed medication to lower blood sugar (for diabetes)?
    - ___ days
    - ☐ None
    - ☐ Not applicable
    - ☐ Don't know/Not sure
    - ☐ Don't want to answer

11. Do you measure your blood pressure at home or using other calibrated sources?
    - ☐ Yes
    - ☐ No, was never told to measure
    - ☐ No, don't know how to measure
    - ☐ No, don't have equipment to measure
    - ☐ Don't know/Not sure
    - ☐ Don't want to answer

12. How often do you measure your blood pressure at home or using other calibrated sources?
    - ☐ Multiple times per day
    - ☐ Daily
    - ☐ A few times per week
    - ☐ Weekly
    - ☐ Monthly
    - ☐ Don't know/Not sure
    - ☐ Don't want to answer

13. Do you regularly share blood pressure readings with a health care provider for feedback?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/Not sure
    - ☐ Don't want to answer

14. How many cups of fruit do you eat in an average day?

    Examples: 1 cup = 1 large orange or banana; 1 medium pear or grapefruit; 1 small apple; 8 large strawberries; 15 grapes; ½ cup dried fruit such raisins, prunes or apricots; 2–3 plums; 1 large peach; 1 small watermelon wedge; 1 large cantaloupe wedge; 1 cup of 100% fruit juice; 1 cup applesauce; etc.

    ___ cups

15. How many cups of vegetables do you eat in an average day?

    Examples: 1 cup = 1 large bell pepper; 1 ear of corn; 1 tomato; 1 cucumber; 1 medium potato; 1 large sweet potato; 1 cup cooked greens; 2 cups raw leafy greens, such as lettuce or spinach; 2 medium carrots or 12 baby carrots; 2 large stalks of celery; 1 cup dry beans; 1 cup corn; 1 cup cauliflower; 1 cup broccoli; 1 cup green wax beans; 1 cup peas; 1 cup mushrooms; 1 cup onions; 1 cup cabbage; etc.

    ___ cups

16. Do you eat 2 servings or more of fish weekly?

    Example: 1 serving size = palm of hand or deck of cards

    - ☐ Yes
    - ☐ No

17. Do you eat 3 ounces or more of whole grains in an average day?

Examples: 1 ounce = one slice of whole wheat or rye bread; 1 cup of whole grain cold cereal; ½ cup of oatmeal, brown rice, or whole wheat pasta; 1 small whole wheat or corn tortilla; etc.

☐ Yes ☐ Don't want to answer
☐ No

18. Do you drink less than 36 ounces (450 calories) of beverages with added sugar weekly?

Examples: Non-diet soda; fruit drink, like lemonade, or other sweetened beverages such as Kool-Aid, sweet tea, etc.

☐ Yes ☐ Don't want to answer
☐ No

19. Are you currently watching or reducing your sodium or salt intake?

☐ Yes ☐ Don't want to answer
☐ No

20. How many minutes of moderate physical activity do you get in a week?

Examples: Moderate activities are those that make you breathe a little harder but still allow you to talk while you do them, such as brisk walking, bicycling, vacuuming, gardening, water aerobics, tennis doubles, dancing, etc.

___ minutes ☐ Don't want to answer
☐ None

21. How many minutes of vigorous physical activity do you get in a week?

Examples: Vigorous activities make you breathe harder and make it difficult to talk, such as race walking, jogging, running, swimming laps, tennis singles, jumping rope, hiking uphill or with a backpack, etc.

___ minutes ☐ Don't want to answer
☐ None

22. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form).

☐ Yes, current smoker ☐ Never smoked
☐ Quit 1–12 months ago ☐ Don't want to answer
☐ Quit more than 12 months ago

23. About how many hours a day, on average, are you in the same room or vehicle with another person who is smoking?

___ hours a day ☐ None
☐ Less than one ☐ Don't want to answer

24. Thinking about your physical health, which includes physical illness and injury, on how many days during the past 30 days was your physical health not good?

___ days ☐ Don't want to answer
☐ Don't know/Not sure

25. Thinking about your mental health, which includes stress, depression, and problems with emotions, on how many days during the past 30 days was your mental health not good?

___ days ☐ Don't want to answer
☐ Don't know/Not sure

26. During the past 30 days, on about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

___ days ☐ Don't want to answer
☐ Don't know/Not sure

Section 5: Do you need a ride?

Ladies First can cover the cost of transportation to appointments. Do you need a ride to your Ladies First appointment?

☐ Yes ☐ No

Section 6: How did you find out about Ladies First?

☐ Doctor, nurse or medical clinic. Name: _____

☐ Pamphlet or poster. Where? _____

☐ Ladies First website ☐ Friend, relative or someone who has used the program. Name: _____

☐ Somewhere else. Please tell us where: _____

How can Ladies First reach more women like you? _____

Section 7: Member consent – rights and responsibilities: Please read this page before signing below.

- I understand that by completing this consent form, I am enrolling in the Ladies First Program, a program of the Vermont Department of Health. I understand that Ladies First is a program supported by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and the WISEWOMAN Program (Well Integrated Screening and Evaluation of Women across the Nation), programs of the Centers for Disease Control and Prevention (CDC). The NBCCEDP exists to provide uninsured and underserved women access to timely breast and cervical cancer screening and diagnostic services. WISEWOMAN exists to provide uninsured and underserved women with chronic disease risk factor screening, lifestyle programs, and referral services in an effort to prevent cardiovascular disease.
- I acknowledge that Ladies First is a breast, cervical and heart health screening program and that the program **does NOT cover the costs of care that are not associated with these screening services.**
- I acknowledge that the Ladies First program provides program members with access to preventive services, including screenings for cardiovascular disease risk factors (assessment of body mass index, blood pressure, cholesterol and blood sugar/glucose), risk reduction counseling, medical follow up (if required) and healthy behavior support options in an effort to prevent cardiovascular disease.
- I understand that Ladies First only pays for certain tests. Ladies First **does not pay for ANY cancer treatment**. I have talked to someone from the Ladies First program or the health clinic about what choices I have, and understand that I may have to pay for some tests and treatment that Ladies First does not cover.
- I understand that Ladies First has rules about who may enroll in the program. Ladies First members can have private insurance. If I have private insurance, my insurer will be billed first. Ladies First is unable to enroll women who have Medicaid or Medicare Part B. All of the information I have given is true as far as I know.
- I understand that when I enroll in Ladies First I am giving permission for the program to share information about my eligibility with other Agency of Human Services programs in order to coordinate services.
- I understand that when I enroll for Ladies First I am giving permission for the program to share personal health information related to breast and cervical cancer screenings, heart disease risk factor screening, and diagnosis and treatment care to be shared with my doctor, nurse, hospital, clinics, health care providers involved in my tests and treatment. My information is also shared with the Centers for Disease Control and Prevention (the National Breast and Cervical Cancer Early Detection Program and the WISEWOMAN Program). Ladies First is very careful to keep my information private.
- I understand that Ladies First looks at the health and demographic information of women enrolled in the program to help improve the health of all women.
- I authorize my doctor, clinic, hospital, the laboratory, and lifestyle programs to share my information with the Ladies First Program so that they can make sure I receive the highest quality care. The information is also needed in order for Ladies First to pay my medical bills.
- I understand that I have the right to withdraw from the Ladies First program. If I no longer want to be enrolled in the program, I will inform Ladies First so that I can be withdrawn. Please send a letter to: **Vermont Department of Health, P.O. Box 70, Drawer 38, Burlington, VT 05402-0070 or call our Member Services Coordinator at 1-800-508-2222**.

Acknowledgement & signature – please read carefully

To apply for Ladies First, you must sign below. Unsigned applications will not be processed and will be returned for signature. By signing below:

- I hereby acknowledge that I have completed the application and have read and understand the member consent.
- I also acknowledge that I received a copy of the Notice of Privacy Practices.
- I authorize Ladies First to access and share my health information for the above purposes for as long as I am part of this program.
- I understand that my membership in Ladies First may start up to three months before the date signed below, allowing Ladies First to pay eligible claims during that period.

Signature: _____ Date: _____

VERMONT

Agency of Human Services
Notice of Privacy Practices

This notice takes effect as of May 5, 2009

Please review carefully

This notice describes how medical and drug and alcohol related information, and other individually identifiable information about you, may be used and disclosed and how you can get access to this information.

"We" are the Agency of Human Services (AHS). AHS includes the Department for Children and Families; the Department of Disabilities, Aging and Independent Living; the Department of Health; the Department of Mental Health; the Department of Corrections; and the Office of Vermont Health Access. Our contractors and grantees include service providers throughout Vermont, such as parent-child centers, adult day centers, and community mental health centers.

When we provide you with health and social services, we will obtain individually identifiable information (identifying information), and sometimes health information, about you. Federal and state laws require us to protect this information.

This notice tells you about how we may use or share your identifying and/or health information and when we may not do so. It also tells you about your rights. The law requires that we give you this notice. The law requires us to follow the terms of the notice currently in effect.

FREE INTERPRETER SERVICES ARE AVAILABLE

Please tell us if you need an interpreter or other accommodation in order to read and understand this notice.

Veuillez nous faire savoir si vous avez besoin d'un interprète ou d'autres dispositions afin de lire et comprendre le présent avis.

Indique si necesita un intérprete u otro tipo de asistencia para poder leer y comprender esta notificación.

Molimo Vas obevestite nas ukoliko Vam je potreban prevodilac ili neka druga vrsta pomoći kako bi lakše razumeli ovo obaveštenje.

Tafadhali tuarifu kama unahitaji mkalimali au msaada mwingine ili uweze kusoma na kuelewa notisi hii.

Fadlan noo sheeg hadii aad doonayso turjibaan ama in lagaa caawiyo aqriska ama fahanka ogaysiiskaan.

ဤကြေညာချက်အား ဖတ်ရှုနားလည်ရန် စကားပြန် (သို့) အခြားလိုက်လျောမှု လိုအပ်ပါက ကျေးဇူးပြု၍ ကျွန်ုပ်တို့အား ဖော်ပြပါ။

ၦ့ၤတစကၠ ငွ္ကြ လ်က ခဆဝက်ိဳ ပ်ိထ မငုဘဇပေ့ဘဇ ညုံ္ရ္ဍ သု လ္ကးၤဆ်သို္ဍ လုသဒိးမ္ဒၤ ကျ=ိငး္ၤနပုဘဇ ခမှကဆ္ဍိပုဗ

Privacy practices regarding: Health information

1. What health information does AHS have about me?

You and others may give us information about your health and health care when you apply for or receive our services. This may include information about your diagnosis, disability or treatment. This may also include financial and billing information.

2. What health information does AHS use and share?

We use and share only the minimum necessary health information that our staff or our contractors need to do their jobs.

3. When does AHS use or share my health information?

We may use and share your health information for treatment, payment, or health care operations which includes service planning and AHS administration. For example, we may use your information for the following reasons:

- To determine your eligibility for services or benefits
- To create and provide individualized service or treatment plans.

For example, we may share your information to make a plan for your treatment with nurses, doctors and other health care workers who treat you.

- To remind you of appointments.
- To tell you of other service supports or treatments that may be helpful to you or your family.
- To pay for your services.

For example, your doctor may send us your health information so that we can pay her.

We may also share your health information with contractors so that they can pay your doctor for us.

- To carry out our operations and manage our programs.

For example, we may use and share your health information to make sure people who care for you give you high quality services and are paid promptly and correctly. We may use and share your information to make sure you get the right services and to improve the services that you get.

4. Are there other times that AHS uses and shares my health information without my authorization?

There are limited times when we use and share information without your authorization. Sometimes the law allows or requires us to do this.

We may share your information without your authorization for the following personal reasons:

- With a family member or any other person you choose, relevant to their involvement in your care or payment for your care.
- To notify your family or other person responsible for your care of your location, condition or death.
- To a funeral director or medical examiner who needs the information to carry out their duties.
- For worker's compensation or other similar programs.

We may share your information without your authorization for the following special reasons:

- For public health activities such as preventing or controlling disease, injury or disability, and for keeping vital records of things such as births and deaths.
- For research purposes, subject to strict legal restrictions.
- With organizations that provide for organ donation and transplants.
- In response to a court or administrative order, subpoena, discovery request, or other process.
- To the police when required by law.
- To report a crime committed on our premises or against our staff.
- To report abuse or neglect to the appropriate authorities.
- To a health oversight agency for oversight activities authorized by law such as audits and investigations.
- To the United States Department of Health and Human Services for a compliance review or complaint investigation.
- To avoid a serious threat to the health or safety of a person or the public, or for law enforcement to identify or apprehend an individual.
- To carry out specialized governmental functions, such as to protect public officials, for national security, for military affairs, and to correctional institutions for certain purposes.
- With another agency administering a government program providing public benefits, with respect to eligibility or enrollment information, and to better coordinate, administer and manage related government programs.

Except for the reasons stated in this notice and permitted by law, we will not use or share your health information without your written authorization.

5. What if someone else needs my health information?

You may ask that we give your information to others, or we may ask your permission to do so. Before we share any information, you will be asked to sign an authorization form. The authorization form tells us what information to share, the purposes for sharing, and the identity of the person(s) with whom we will share. You can cancel your authorization at any time.

6. May I see my health information?

In most cases, you may see your health information. You should ask the Privacy Officer, in writing, to see it or to get a copy of it (see contact information on page 7). Safety or other legal reasons may limit the information that you see. We may charge a reasonable amount for copying.

7. May I change my health information?

If you think some of your health information in your record is incorrect, you may ask in writing that we correct it or add new information. You may ask that we send the corrected or new information to others who have received your health information from us.

We may not make the changes or additions if in our opinion the information is already accurate and complete or for other reasons. If we do not agree to change your information, we will tell you, in writing, why we do not agree. We will also note in your record that you asked us to change your information and that we did not agree to change it.

8. May I ask AHS to restrict how it uses and shares my health information?

You may ask that we restrict how we use and share your health information. Your request must be in writing and tell us what restrictions you want. We will consider your request but are not required to agree with it.

9. May I request that AHS communicate with me in a confidential way?

You may ask that we communicate with you by reasonable alternative means or at an alternative location. Your request must be in writing and tell us where and how we should contact you. We will try to honor your request.

10. May I get a list of when AHS has shared my health information with someone?

You may ask for an accounting of disclosures of your health information by us. You must make your request in writing to the Privacy Officer. The law does not require us to list every situation in which we have shared your information. For example, we do not have to list those times that we shared your information for AHS treatment, payment or health care operations or when we shared your information pursuant to an authorization signed by you.

11. What laws does AHS follow that apply to the privacy of my health information?

We follow the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA. We also follow any federal or state laws that give you greater privacy protections than HIPAA, whenever they apply. For example, we follow the federal confidentiality law concerning substance abuse treatment programs, 42 CFR Part 2, and state confidentiality laws concerning mental health records, 18 VSA § 7103.

12. May I have a copy of this notice?

Yes, you are entitled to a copy of this notice. You may ask us for a copy at any time. An electronic version is on our website, www.ahs.state.vt.us.

13. Can AHS change its privacy practices?

We reserve the right to change our privacy practices and this notice. Any changes in our practices will apply to information about you that we already have and to information that we receive in the future. We will post a copy of any new notice on our website, www.ahs.state.vt.us, and provide it to you by mail.

14. Who do I contact if I have questions about this notice?

Please contact the Privacy Officer by phone at 802-769-2160 or by mail at:

AHS Privacy Officer
Office of the Attorney General
103 South Main Street
Waterbury VT 05671-1201

15. How do I complain if I believe that my privacy rights have been violated?

You can complain to our privacy officer in writing or by phone. You can also complain to the Office for Civil Rights, DHHS, JFK Federal Building Room 1875, Boston, MA 02203.

You will not be retaliated against for filing a complaint. Benefits or services that you receive will not be affected by any complaint that you make to the AHS Privacy Officer or to the Office for Civil Rights.

Violations of 42 CFR Part 2 (drug and alcohol confidentiality law) is a crime. Suspected violations of this law may be reported to the United States Attorney in the district where the violation occurred.

VERMONT

Agency of Human Services
Notice of Privacy Practices

This notice takes effect as of May 5, 2009

Please review carefully

Privacy practices regarding: Individually identifiable information

In addition to health information privacy practices, AHS has guidelines concerning the confidentiality of information that identifies the individuals to whom we provide benefits and services.

What is individually identifiable information?

This is information created or received by AHS or its contractors or grantees that identifies, or reasonably could identify, an individual who receives services or benefits from AHS. Examples of identifying information are:

- Name
- Social security number
- Date of birth
- Address
- Phone number

When does AHS share or disclose my identifying information without my permission?

We may share or disclose your identifying information for our own program administration without your permission. Program administration means activities necessary to carry out the operations of AHS and consist of the following:

- Establishing eligibility and scope of services and assistance for which you have applied, including the identification and coordination of these services within AHS and with its contractors and grantees.
- Planning, providing, arranging, funding or paying for services and assistance for individuals and families.
- Coordination of benefits.
- Detecting fraud and abuse.
- Engaging in quality control and improvement activities.
- Emergency response and disaster relief.
- Complying with federal and state legal, reporting and funding requirements.

When does AHS need to have my permission before sharing or disclosing my identifiable information?

We need your written permission to share or disclose your identifying information in order to:

- Consider your eligibility for services other than those for which you have already applied.
- Coordinate your services with your providers who do not have a contract or grant with us.
- Consult with professionals outside of AHS in order to benefit from their expertise.
- Share with the persons of your choice.

If you do not give permission in the above circumstances, we may not be able to provide the full quantity and quality of services that may be available to you.